STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235625	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a person-centered care plan for 1 (Resident #2) of 3 residents reviewed for person centered care planning resulting in the potential for injury and unmet care needs.Findings include:Resident #2Review of an admission Record revealed Resident #2 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: other displaced fracture of sixth cervical vertebra (fracture of the 6th vertebra in the neck area), syncope (fainting) and collapse, and weakness.Review of History and Physical dated 12/6/25 revealed .had a syncopal (passing out) episode this morning.On standing he lost consciousness, fell and struck his head.has neck pain.a scalp laceration (cut) was sutured (stitches).MRI (magnetic resonance imaging an non-invasive technique that produces detailed images of the internal structures of the body) showed an anterior superior vertebral body fracture (a type of compression fracture occurring at the front upper part of a vertebra, often caused by trauma). he is stabilized in an Aspen collar.recommended Aspen collar and f/u (follow up) Xray in 4 weeks .Review of After Visit Summary (AVS) for Resident #2 dated 12/12/25 revealed .discharge instructions (specific in comments) continue to wear Aspen collar splint designed to provide firm yet comfortable immobilization of the neck (prevents movement of the neck)) at all times. Review of Health Care Provider Note for Resident #2 dated 12/15/25 revealed .sustained a C6 (6th cervical vertebra fracture) cervical fracture.Assessment and plan.C6 cervical fracture-Aspen collar.seen heading to therapy in C-collar (Aspen collar).Review of Care Plan for Resident #2 revealed no noted documented care plan related to a cervical fracture or the use of an Aspen collar.Review of Interdisciplinary Documentation for Resident #2 dated 12/16/25 at 10:27 (am) revealed .is alert and oriented with some confusion. Continuously removed aspen collar despite education to keep it in place per provider orders. He is unsteady and requires assistance of 2 for bed mobility, transfers, and ambulation.In an interview on 1/16/26 at 11:42 AM, Infection Prevention Manager/Registered Nurse (IPM/RN) L reviewed Resident #2's record and confirmed there was no care plan in place for a C6 fracture or the use of an Aspen collar. IPM/RN L reported there should be a care plan in place. IPM/RN L reported clinical care coordinators were responsible for creating care plans, and that Clinical Care Coordinator/Registered Nurse (CCC/RN) EE was assigned to Resident #2 and should have created the care plan for his C6 fracture and his Aspen collar.In an interview on 1/16/26 at 12:08 PM, Director of Nursing (DON) B reported the clinical care coordinators were responsible for the development of resident centered care plans. DON B reported Resident #2 had an Aspen collar he was to wear at all times, but he would play with it more than he wore it. DON B reported there should have been a care plan in place related to Resident #2's C6 fracture and Aspen collar. DON B reported CCC/RN EE was responsible for the unit Resident #2 resided on and should have created his care plan at admission.CCC/RN EE was not available for interview during the survey.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2698524Based on interview and record review the facility failed to adequately assess and treat a resident experiencing an acute change of condition timely for 1 (Resident #1) of 3 residents reviewed for quality of care, resulting in an immediate jeopardy when, on [DATE], Resident #1 was found unresponsive, lethargic, hypotensive (low blood pressure) and 911 EMS (emergency medical services) were not immediately contacted. Resident #1 subsequently died.Findings include:The immediate jeopardy began on [DATE] and was identified on [DATE] due to the facilities failure to assess for an acute change in condition, follow physician orders for medical laboratory testing, and notify 911 EMS when Resident #1 was found unresponsive, lethargic, hypotensive and subsequently died.On [DATE] at 4:55 PM, the Nursing Home Administrator was verbally notified and received written notification of the immediate jeopardy. The surveyor confirmed by observation, interview, and record review the immediate jeopardy was removed on [DATE], but noncompliance remains at scope of isolated and severity of actual harm due to not all staff receiving the education and sustained compliance that has not been verified by the State Agency. Resident #1Review of an admission Record revealed Resident #1 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: bipolar disorder (a mental health disorder characterized by significant mood swings), dementia (a syndrome characterized by a decline in cognitive function affecting memory, thinking, behavior, and the ability to perform everyday activities) and delusional disorder (serious mental health condition characterized by persistent, false beliefs that are not based in reality, often leading to significant distress and impairment in functioning).Review of Interdisciplinary Documentation for Resident #1 dated [DATE] at 03:16 AM (3:16 am) and authored by Registered Nurse (RN) V at 8:19 am on [DATE] revealed .PA (physician assistant) notified of patient's change in condition, including hypotension (83/56 BP Blood pressure).lethargy, cool skin, significant bilateral lower-extremity edema, and blue-to purplish fluid-filled blisters on posterior heels bilaterally. After discussion, PA agreed patient requires hospital evaluation. Hospital notified and report given. Preparation initiated for transfer to hospital. Focus at this time is on facilitating transport and maintain patient safety while awaiting transfer.Review of Interdisciplinary Documentation for Resident #1 dated [DATE] at 08:19 AM (8:19 am) revealed .Patient transferred to hospital for further evaluation per provider recommendation. Report given to receiving hospital staff and transport personnel. Patient departed facility via ambulance in stable condition at time of departure. Facility notified as appropriate. Documentation completed.In a telephone interview on [DATE] at 9:54 AM, EMS [NAME] Specialist (EMS/BS) Z reported on [DATE], the (Name Omitted) local emergency room contacted (Name Omitted) local EMS ambulance services, reported the facility was unable to contact 911 due to a telephone issue, and needed a patient transported from the facility that (Name Omitted) local emergency room had received report on, but did not receive the patient.In a telephone interview on [DATE] at 10:08 AM, 911- Service Specialist (SS) AA reported 911 EMS received two calls for the facility on [DATE], one at 3:20 AM the call was for an ambulance at (Name Omitted), and (Name Omitted) ambulance service was dispatched at 3:25 AM, the call was clear at 5:01 AM. When queried, SS AA reported a call being clear meant the patient that was transported was in the care of the hospital and the ambulance was back in service, available for another call. SS AA reported an abandoned call was received at 5:24 AM from the facility. When queried, SS AA reported an abandoned call indicated a call was made but was disconnected for some reason and no conversation occurred. SS AA reported 911 returned the abandoned call and was informed there was no emergency at the location. SS AA reported 911 received a call at 5:29 AM from the local emergency (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	department and a call at 5:30 AM from the ambulance service, advising they had received a call from the local emergency department, indicating that they had received a call from the facility providing report on a patient and had not received the patient yet. Review on Call for Service Detail Report - CFS 2334 dated [DATE] at 5:29:55 AM revealed .5:30:16 AM (Name Omitted) ambulance service also calling in - advising they got a call from the hospital that THEY got a call from (Name Omitted) facility of an unresponsive male over an hour ago. 5:30:26 AM now getting an [NAME] (abandoned) from (Name Omitted) facility.5:33:04 AM Spoke with (Name Omitted) staff (Name Omitted) Facility who confirmed no emergency.5:33:13 AM close call.5:34:17 AM call reactivated. 5:37:46 AM (Name Omitted) ambulance service just called back- 77 y/o year old female hypertensive, unresponsive- (Name Omitted) Facility said they couldn't get thru to 911- in cardiac arrest - (Name Omitted) ambulance service contact at the hospital is (Name Omitted) at (Name Omitted) local emergency department- .5:39:08 AM ambulance dispatched (unit 4010). 5:41:03 AM per (Name Omitted) ambulance service no police or mfr's (medical first responders) needed.7:39:16 AM call cleared, close call.Review of Incident Detail Report dated [DATE] at 5:36:12 AM revealed .XXX[DATE] 05:36:58 AM, 77 yo (year old) female called in by (Name Omitted) ER (emergency room), (Name Omitted) facility staff said they were unable to get ahold of (Name Omitted) 911 due to phone issues.Review on Prehospital Care Report Summary for Resident #1 dated [DATE] revealed . call received 05:36:12 (5:36 am), dispatched at 05:37:05 (5:37 am).Initial patient acuity: Emergent (yellow).Lights and sirens, destination.Dispatch reason: 9 cardiac or respiratory arrest/death.Provider impression. unconscious. Vitals. 5:49:32 (5:49 am) BP 136/108 (normal value - 110/75 to 130/85 with 120/80 being standard normal reading), Pulse 79 (normal value - 60 to 100 beats per minute), Resp (respirations, normal value - 12 to 20 per minute) 24, SpO2 62 (normal value - 90 to 100 with readings below 90 requiring immediate medical attention). 05:57 am BP 161/122, Pulse 95, SpO2 85. 5:59 am, 177/144, Pulse 114, Resp 23, SpO2 89. 6:03 am BP 192/155, Pulse 100, Resp 31, SpO2 78.6:11 am, 197/166, Pulse 67, Resp 25. Narrative History Text: was dispatched to (Name Omitted) facility for a reported full cardiac arrest. Upon arrival, the crew was met at the entrance by facility staff.Two staff members were present in the room. No CPR or ventilations were in progress. when asked for the latest status update, staff stated the patient was breathing now and has a pulse and then exited the room to retrieve paperwork. The patient was found unconscious, breathing spontaneously, with a palpable pulse. The patient was warm to the touch and was receiving oxygen via nasal cannula (a medical device used to deliver oxygen to a patient through their nostrils) at 3 LPM (liters per minute). initial heart rate and pulse oximetry (SpO2- measure oxygen saturation of the blood) were obtained, SpO2 was noted low. oxygen was increased to 6 LPM vial nasal cannula.Once loaded. patient remained minimally responsive. Due to continued hypoxia (low levels of oxygen in the body tissues) and mental status, oxygen delivery was upgraded to a non-rebreather mask at 15 LPM.ETCO monitoring (End Tidal Carbon Dioxide monitoring used to assess a patient's respiratory status and overall health. Measure the concentration of carbon dioxide in exhaled are at the end of a respiration) was applied, revealing tachypnea (rapid respirations) with low CO2 values (inadequate amounts of carbon dioxide being expelled from the body) The patient remained unresponsive to verbal stimuli and responsive only to painful stimuli (sternal rub).radio report was given and acknowledged to (Name Omitted) local emergency department. care was documented as transferred to emergency department at 06:21:42 (6:21 AM).Review of ED to Hosp-admission (Discharge) in (Name Omitted) critical care Discharge Note for Resident #1 revealed .XXX[AGE] year old lady with dementia with psychotic features, major depressive disorder, atrial fibrillation (irregular heart rhythm) on Eliquis (blood thinner medication).was brought in on [DATE] from her health care facility (Name Omitted) where she was found unresponsive. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On EMS arrival patient was hypotensive (low blood pressure), tachycardic, (fast heart rate). cool and cyanotic (blue in color indicated poor blood circulation) extremities (arms and legs). Upon arrival to the ER patient continued to be comatose.and was intubated for airway protection. Notably during intubations, provider noted crushed pill remnants in the back of the throat with concern for polypharmacy versus aspiration of medication. infectious workup. urinalysis concerning for UTI.Hospital course complicated by recurrent hemodynamically unstable (the body's circulatory system cannot maintain adequate blood flow often leading to shock) SVT (Supraventricular tachycardia, a fast or erratic heart rhythm) requiring multiple synchronized cardioversions (quick low-energy shocks to a patient's heart to restore a regular rhythm) . furthermore patient's blood pressure continued to plummet despite escalating doses of vasopressor (medications used to raise blood pressures). concerns for cardiogenic shock (a life-threatening condition characterized by the heart's inability to pump enough blood to meet the body's needs leading to severe symptoms and potential organ failure) on top of sepsis (a life-threatening condition caused by the body's extreme response to an infection) .Patient's condition continued to worsen and blood started oozing out of from all IV (intravenous) access points and repeat labs were concerning for DIC (Disseminated intravascular Coagulation is a rare blood clotting disorder that can cause organ damage and uncontrollable bleeding and can occur as a complication of a very serious medical condition such as an infection). ICU (Intensive Care Unit) team had multiple discussions with patient's family and POA about her worsening medical condition, guarded prognosis, and ultimately family decided to proceed with comfort measures in keeping with patient's wishes. Patient was pronounced deceased at 2319 on [DATE].In a telephone interview on [DATE] at 3:03 PM, Certified Nurse Assistant (CNA) W reported she was assigned to the back unit but not directly to Resident #1 during the overnight shift on [DATE] to [DATE] and that Resident #1 was her usual self at the beginning of the shift, and then, all of the sudden, in the middle of the shift she was out of it. CNA W reported she informed the nurse, Registered Nurse (RN) V that something was wrong with Resident #1. CNA W reported that night Resident #1 could not keep her eyes open and she was very out of it. CNA W reported that herself, RN V and RN P checked on Resident #1 frequently, took her vital signs several times, and both nurses made several phone calls that night. CNA W reported there was more than one resident that went to the hospital that night, and that Resident #1 was the second resident to go to the hospital. CNA W reported she could only recall RN V and RN P working that night, she could not recall a third nurse.In a telephone interview on [DATE] at 4:15 PM, CNA T reported she worked the night shift from [DATE] to [DATE] and remembered that RN V wanted to send Resident #1 to the hospital. CNA T reported RN V was completing the steps, notifying chain of command, completing paperwork and working with her partner, RN P to send Resident #1 to the hospital. CNA T reported she recalled RN P was not as convinced as RN V that Resident #1 needed to be transported to the emergency department for evaluation. CNA T reported she could not recall if there was a third nurse that worked that night.In a telephone interview on [DATE] at 4:43 PM, CNA F reported Resident #1 was fine at the beginning of the overnight shift on [DATE] to [DATE], and sometime in the middle of the shift Resident #1 became completely unresponsive. CNA F reported RN V did everything she possibly could do to get her sent out to the hospital. CNA F reported RN V made lots of phone calls and it seems like she could not get ahold of the people in the chain of command to get permission to send her out.In a telephone interview on [DATE] at 4:51 PM, CNA K reported she worked the night shift from [DATE] to [DATE], was not assigned to the unit Resident #1 resided on but did recall that she went out to the hospital that night. CNA K reported there were two nurses working that night, RN V and RN P. CNA K reported she did not recall a third nurse that night. In a telephone interview on [DATE] at 5:13 PM, RN (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	V reported she and RN P were the only two nurses working on [DATE] to [DATE] night shift. RN V reported RN P was assisting her to complete her orientation check list including transferring a resident to the hospital, as she had not yet competed that part of her training. RN V reported everything happened at about 3 AM that night, and there were only the two of us nurses in the building. RN V reported both her and RN P assessed Resident #1, and they noticed that her vital signs were fluctuating, she appeared to be in pain, and she was not responding. RN V reported Resident #1 was not responding, but when they did a sternal rub, she flinched and that was not her baseline. RN V reported RN P told her that Resident #1 did not need to be transported to the hospital yet, her vitals were stable. RN V reported when she would take Resident #1's vitals she would get one reading and when RN P would take them they were completely different. RN V reported Resident #1's vitals were wonky, and she knew that wasn't right. RN V reported Resident #1's hands were cold, and the pulse oximetry wasn't working correctly, and she couldn't get a reading. RN V reported she contacted the on-call provider, received a verbal order to transfer to the emergency department. RN V stated I remember talking to the provider and he asked me what my recommendations were and I said send her to the hospital. RN V reported RN P was assisting her with completing the paperwork for a transfer to the hospital, the steps to take, the check list to be completed, and the packet that had to be filled out. RN V stated I asked (RN P) should we just call 911 and RN P told me to finish up the packet, paperwork, she was going to go eat something, and then she would help me again when she was done. RN V reported she had transferred another resident to the hospital that night, and she stated I learned that 911 comes really fast and if you don't have the paperwork filled out, they won't wait for you, and then they don't have what they need. RN V reported the packet needs to be filled out and the transfer sheet, call the family, call report to the hospital and then call 911. RN V reported she went through the transfer paperwork and the program prompts line by line to answer the questions and then the sections turn green when they are completed. RN V reported she had more questions, but RN P wasn't available, so she continued completing the form. RN V reported at the bottom of the transfer form was a section where it asks who you called report to and RN V reported when she got to that line in the transfer form, I called the hospital and provided report to a nurse in the local emergency department. RN V reported she recalled that she did not complete the paperwork correctly for the first resident she transferred from the facility this shift, so the second time she took her time to make sure all the paperwork and transfer forms were completed before the ambulance arrived to transport the patient. When queried, if RN V recalled when she called 911 for Resident #1 to be transported to the hospital, RN V replied No, I didn't call 911, I thought RN P called them. I remember 911 called the facility after 5 AM, RN P spoke to them, and Resident #1 was picked up after that.Review of SNF/NF (skilled nursing facility/nursing facility) to Hospital Transfer Form for Resident #1 dated [DATE] 04:00 am revealed .last vital signs were 124/70, pulse 70, respiration 18, temp 98.4, and SpO2 95%, all recorded on [DATE].reported called to (Name Omitted) Registered Nurse on [DATE] at 04:00 AM.In a telephone interview on [DATE] at 9:42 AM, Physician Assistant (PA) BB reported it is not standard that on-call providers document a call received when providing on call support to the facility. PA BB reported he did not know what time he was contacted by the facility regarding Resident #1 but review of the notes from RN V indicated she spoke with him before 3 am. PA BB reviewed RN Vs documentation in Resident #1's record, and stated the facility should have sent her (Resident #1) to the hospital right after we spoke, I certainly wouldn't have told them to wait for transfer.In an interview on [DATE] at 3:30 PM, Nurse Practitioner (NP) CC reported on the Thursday ([DATE]) Resident #1`s roommate stopped her in the hallway and told her Resident #1 was not feeling good. NP CC stated she (Resident #1) was (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nurses. DON B reported there were always 3 nurses for the evening medication pass in the building; if there was a nurse call in then the staffing manager tries to cover the shift, otherwise a clinical care coordinator or the DON B would cover the open shift. DON B reported when covering a shift, the nurse covering only had to stay through completion of the evening medication pass. DON B stated .I have been in the building after 10 (PM) and there isn't much to do other than a few PRN's (as needed medications) and dressing changes, you don't need 3 nurses.In an interview on [DATE] at 12:33 PM, Director of Nursing (DON) B reported if a resident had a change in condition her expectations were that the nurse was to call the on-call provider, and the nurses will make the decision if the resident needs to be transferred to the hospital. DON B reported an assessment should be done, call to on call provider, complete the transfer form on the computer, the transfer packet, and call 911-EMS for transport. DON B reported her expectations were that the other nurses in the building helped where needed. DON B reported if a resident was assessed and the change was more serious, then the resident needs to be transferred quicker than someone who wasn't as serious. When queried, DON B reported her expectations for a resident was unresponsive would be for transfer to happen immediately. DON B reported the telephone system in the building was a voice over IP internet service and they did go down at times. DON B reported there is a second Wi-Fi access that can be used, and the expectations are that the staff switch to their personal cell phones when calls need to be made. DON B reported she was on vacation when Resident #1 was transferred to the hospital on [DATE]. DON B reported the at about 3:00 am on [DATE], facility staff did notify her that Resident #1 was being sent to the hospital for evaluation, and she instructed them to notify IPM/RN L as she was on call that night.In an interview on [DATE] at 12:57 PM, Infection Prevention Manager/Registered Nurse (IPM/RN) L reported she did not receive any call from the facility during the overnight hours on [DATE] to [DATE]. IPM/RN L reported she was walking in the front door when Resident #1 was exiting the building with EMS on a stretcher headed to the ambulance for transport. IPM/RN L reported she punched in on [DATE] at 5:48 AM.In an interview on [DATE] at 12:52 PM, Nursing Home Administrator (NHA) A reported there was no phone outage on [DATE] or [DATE]. NHA A reported the phones do go down and can be reconnected to a different Wi-Fi connection.The immediate jeopardy began on [DATE] and was removed on [DATE] when the facility took the following actions to remove the immediacy.On [DATE] all licensed nurses were immediately re-educated that 911 EMS must be called without delay for any resident exhibiting signs of an acute decline, including but not limited to unresponsiveness, hypotension, altered mental status, respiratory distress, or other emergent conditions.Staff were instructed that contacting the emergency department or hospital does not replace activation of 911 EMS.An emergency response protocol reeducation requiring immediate activation of 911 followed by notification of the supervisor or administrator on call. The monthly on call schedule was posted on the back wall at the nurse's station.The Director of Nursing or designee are available 24 hours a day, 7 days a week to support clinical decision-making during all shifts.Re-education began on [DATE] and will be completed in person or by telephone prior to their next scheduled shift being worked.No licensed staff will be allowed to start a shift or give care until education is completed.Medical director was notified on [DATE].A verbal conversation followed by agreement indicated facility health care providers as of [DATE] will enter their own orders into the electronic medical record. As of [DATE] 100% of facility health care providers' orders are electronic.A facility wide review of all current residents was initiated on [DATE] and will continue until complete to identify those at risk for acute clinical decline.On [DATE] all residents exhibiting signs of deterioration were immediately assessed and transferred via EMS and the emergency response protocol.On [DATE] a licensed nurse will conduct a chart review of all current (continued on next page)

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	235625	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents for change in condition and follow through with the health care practitioner orders this audit will continue until complete.As of [DATE], 6 of 10 registered nurses were educated; 3 of 7 Licensed practical nurses were educated, and 2 of 4 agency nurses were educated. As of [DATE], 10 licensed nurses have not been re-educated with 3 licensed nurses on a leave of absence. All licensed nurses will receive education prior to their next worked shift.Agency licensed nurses will be educated and will complete a competency test prior to their shift worked. The facility change in condition policy was reviewed on [DATE] by the interdisciplinary team and updates made to clearly require the activation of 911.On [DATE] emergency condition decision-support tools were implemented at the nurse's station.On [DATE] leadership oversight implemented to review all emergency transfers.

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake # 2698524Based on interview and record review the facility failed to ensure sufficient staffing to meet the needs and maintain the highest practicable well-being of 1 (Resident #1) of 1 resident reviewed for sufficient staffing, resulting in a delay in treatment for Resident #1, who experienced an acute change in condition and was not transported timely to an acute care facility and subsequently died.Findings include: Review of an admission Record revealed Resident #1 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: bipolar disorder (a mental health disorder characterized by significant mood swings), dementia (a syndrome characterized by a decline in cognitive function affecting memory, thinking, behavior, and the ability to perform everyday activities) and delusional disorder (serious mental health condition characterized by persistent, false beliefs that are not based in reality, often leading to significant distress and impairment in functioning).In an interview on [DATE] at 12:53 PM, Staffing Manager (SM) E reported staffing was directed by a staffing matrix from corporate and the matrix was based on census. SM E reported when census was above 74 resident there should be 3 nurses working on day shift and 3 nurses working on night shift, working 12-hour shifts. SM E reported when the census was 73 staffing for nurses should be 3 working on day shift and 2 working on night shift. SM E reported if there was a call in for the night shift, a day shift nurse was required to stay over and complete the evening medication pass, no longer than 4 extra hours. SM E reported she tried to staff 3 nurses on the night shift, but if there was a call in or a hole in the schedule, a day shift nurse had to stay over, and there may not be other coverage when the day shift nurse left at 11 PM. SM E reported on the night shift starting on [DATE] and ending on [DATE] there were three nurses scheduled but one called in. SM E reported only one clinical care coordinator, and the director of nursing could help fill an open shift on the floor.Review of the Clinical Time Punches revealed . Registered Nurse (RN) V and RN P were the only two nurses clocked in for the entire overnight shift [DATE].Review of Daily Census Report for [DATE] revealed .census was 75.Review of Staffing Matrix provided by SM E revealed for a .census count of 75 residents the nurse supervisors on both the day and night shift should be 3 each. No noted indication for the use of resident acuity (severity of a person's illness) was listed.Review of Facility Assessment with a reviewed date of 10/2025 provided by Nursing Home Administrator (NHA) A revealed .How did the facility determine resident staffing level.the facility identified minimum staffing with evaluation of acuity and diagnosis which will ensure the needs of the residents are met while providing overall safety. The staffing level planned is reflective of current staffing with tasks considered. Clinical leadership. will be utilized during staffing needs.Licensed Nurses (LN): RN, LPN, LVN providing direct care . RN or LPN charge nurse: 3-4 on day and evening shift and 3 on night shift.In a telephone interview on [DATE] at 4:43 PM, CNA F reported on [DATE] to [DATE] on the night shift there were only two nurses working when Resident #1 and another resident had to be transported to the hospital. CNA F reported RN V was the nurse responsible for both residents that shift. CNA F reported . once you're in the back on the east or south unit, you're back there; You do not go to other parts of the building; the acuity and the need of the residents was too high in those units.In a telephone interview on [DATE] at 3:45 PM, CNA S reported staffing could be better. CNA S reported she made it a point to get the tasks done for the residents, but some CNAs only work 8-hour shifts and leave in the middle of a 12-hours shift. CNA S reported if a CNA leaves at 10:30 PM, the remaining CNA's have 15-16 residents to care for overnight. CNA S reported half of the residents she usually cares for on the south and east wings (the back unit (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	hallways) require two staff members for some of their care. CNA S reported when there were scheduled showers to do, the other residents had to wait until the shower was done before their call lights would be answered. CNA S reported sometimes residents had to wait for a long time, 20 minute or more.Review of Facility data, for the date of [DATE] provided by Nursing Home Administrator NHA A included . census was 75 residents in the facility, of those 75 residents, 35 residents required two or more staff members when assisting with cares such as a transfer.In a telephone interview on [DATE] at 4:15 PM, CNA T reported the nurses work short a lot on night shift. CNA T reported that there were not enough nurses to cover the night shifts. CNA T reported that sometimes there are only 2 nurses scheduled on the night shift. CNA T reported that staffing on night shift can be 5 CNAs and 2 nurses, and when that happens, showers are not always done, Residents may get a quick wash up and most shifts were like that, we don't get our lunch breaks. CNA T reported the back unit (south and east halls) was a very hard unit, the residents on those two units have a higher acuity and more needs to be met. CNA T reported she worked the night Resident #1 was sent to the hospital and Resident #1 was on the east unit.In a telephone interview on [DATE] at 5:13 PM, RN V reported she and RN P were the only two nurses working on [DATE] to [DATE] night shift. RN V reported RN P was assisting her to complete her orientation check list including transferring a resident to the hospital, as she had not yet competed that part of her training. RN V reported everything stared to happened at about 3 AM, and two residents (one of which was Resident #1) had to be transported to the hospital. RN V reported RN P was providing direction to complete the paperwork for a transfer to the hospital. RN V stated I asked (RN P) should we just call 911 and RN P told me to finish up the paperwork, she was going to go eat something, and then she would help me again when she was done. RN V reported she had transferred another resident to the hospital that night, and she stated I learned that 911 comes really fast and if you don't have the paperwork filled out, they won't wait for you, and then they don't have what they need. RN V reported she recalled that she did not complete the paperwork correctly for the first resident she transferred from the facility this shift, so the second time she took her time to make sure all the paperwork and transfer forms were completed before the ambulance arrived to transport the patient. When queried, if RN V recalled when she called 911 for Resident #1 to be transported to the hospital, RN V replied No, I didn't call 911, I thought RN P called them. I remember 911 called the facility after 5 AM, RN P spoke to them, and Resident #1 was picked up after that.In a telephone interview on [DATE] at 9:31 AM, RN P reported that her and RN V were the only two nurses who worked on [DATE] to [DATE], the night that RN V transferred two residents to the hospital. RN P reported she assisted RN V with the paperwork for Resident #1, but she did not call 911. RN P said wait, did I call 911 or did she call 911, yes, yes, I did not call, she did.Review of Interdisciplinary Documentation for Resident #1 dated [DATE] at 03:16 AM (3:16 am) and authored by Registered Nurse (RN) V at 8:19 am on [DATE] revealed .PA (physician assistant) notified of patient's change in condition, including hypotension (83/56 BP Blood pressure).lethargy, cool skin, significant bilateral lower-extremity edema, and blue-to purplish fluid-filled blisters on posterior heels bilaterally. After discussion, PA agreed patient requires hospital evaluation. Hospital notified and report given. Preparation initiated for transfer to hospital. Focus at this time is on facilitating transport and maintain patient safety while awaiting transfer.Review of Interdisciplinary Documentation for Resident #1 dated [DATE] at 08:19 AM (8:19 am) revealed .Patient transferred to hospital for further evaluation per provider recommendation. Report given to receiving hospital staff and transport personnel. Patient departed facility via ambulance in stable condition at time of departure. Facility notified as appropriate. Documentation completed.In a telephone interview on [DATE] at 9:54 AM, EMS [NAME] (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Specialist (EMS/BS) Z reported on [DATE], the (Name Omitted) local emergency room contacted (Name Omitted) local EMS ambulance services, reported the facility was unable to contact 911 due to a telephone issue, and needed a patient transported from the facility that (Name Omitted) local emergency room had received report on, but did not receive the patient.In a telephone interview on [DATE] at 10:08 AM, 911-Service Specialist (SS) AA reported 911 EMS received two calls for the facility on [DATE], one at 3:20 AM the call was for an ambulance at (Name Omitted), and (Name Omitted) ambulance service was dispatched at 3:25 AM, the call was clear at 5:01 AM. When queried, SS AA reported a call being clear meant the patient that was transported was in the care of the hospital and the ambulance was back in service, available for another call. SS AA reported an abandoned call was received at 5:24 AM from the facility. When queried, SS AA reported an abandoned call indicated a call was made but was disconnected for some reason and no conversation occurred. SS AA reported 911 returned the abandoned call and was informed there was no emergency at the location. SS AA reported 911 received a call at 5:29 AM from the local emergency department and a call at 5:30 AM from the ambulance service, advising they had received a call from the local emergency department, indicating that they had received a call from the facility providing report on a patient and had not received the patient yet. Review on Call for Service Detail Report - CFS 2334 dated [DATE] at 5:29:55 AM revealed .5:30:16 AM (Name Omitted) ambulance service also calling in - advising they got a call from the hospital that THEY got a call from (Name Omitted) facility of an unresponsive male over an hour ago. 5:30:26 AM now getting an [NAME] (abandoned) from (Name Omitted) facility.5:33:04 AM Spoke with (Name Omitted) staff (Name Omitted) Facility who confirmed no emergency.5:33:13 AM close call.5:34:17 AM call reactivated. 5:37:46 AM (Name Omitted) ambulance service just called back- 77 y/o year old female hypertensive, unresponsive- (Name Omitted) Facility said they couldn't get thru to 911- in cardiac arrest - (Name Omitted) ambulance service contact at the hospital is (Name Omitted) at (Name Omitted) local emergency department- .5:39:08 AM ambulance dispatched (unit 4010). 5:41:03 AM per (Name Omitted) ambulance service no police or mfr's (medical first responders) needed.7:39:16 AM call cleared, close call.Review of Incident Detail Report dated [DATE] at 5:36:12 AM revealed .XXX[DATE] 05:36:58 AM, 77 yo (year old) female called in by (Name Omitted) ER (emergency room), (Name Omitted) facility staff said they were unable to get ahold of (Name Omitted) 911 due to phone issues.Review on Prehospital Care Report Summary for Resident #1 dated [DATE] revealed . call received 05:36:12 (5:36 am), dispatched at 05:37:05 (5:37 am).Initial patient acuity: Emergent (yellow).Lights and sirens, destination.Dispatch reason: 9 cardiac or respiratory arrest/death.Provider impression. unconscious. Vitals. 5:49:32 (5:49 am) BP 136/108 (normal value - 110/75 to 130/85 with 120/80 being standard normal reading), Pulse 79 (normal value - 60 to 100 beats per minute), Resp (respirations, normal value - 12 to 20 per minute) 24, SpO2 62 (normal value - 90 to 100 with readings below 90 requiring immediate medical attention). 05:57 am BP 161/122, Pulse 95, SpO2 85. 5:59 am, 177/144, Pulse 114, Resp 23, SpO2 89. 6:03 am BP 192/155, Pulse 100, Resp 31, SpO2 78.6:11 am, 197/166, Pulse 67, Resp 25. Narrative History Text: was dispatched to (Name Omitted) facility for a reported full cardiac arrest. Upon arrival, the crew was met at the entrance by facility staff.Two staff members were present in the room. No CPR or ventilations were in progress. when asked for the latest status update, staff stated the patient was breathing now and has a pulse and then exited the room to retrieve paperwork. The patient was found unconscious, breathing spontaneously, with a palpable pulse. The patient was warm to the touch and was receiving oxygen via nasal cannula (a medical device used to deliver oxygen to a patient through their nostrils) at 3 LPM (liters per minute). initial heart rate and pulse oximetry (SpO2- measure oxygen saturation of the blood) were obtained, SpO2 was noted low. oxygen was increased to 6 (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	LPM vial nasal cannula.Once loaded. patient remained minimally responsive. Due to continued hypoxia (low levels of oxygen in the body tissues) and mental status, oxygen delivery was upgraded to a non-rebreather mask at 15 LPM.ETCO monitoring (End Tidal Carbon Dioxide monitoring used to assess a patient's respiratory status and overall health. Measure the concentration of carbon dioxide in exhaled are at the end of a respiration) was applied, revealing tachypnea (rapid respirations) with low CO2 values (inadequate amounts of carbon dioxide being expelled from the body) The patient remained unresponsive to verbal stimuli and responsive only to painful stimuli (sternal rub).radio report was given and acknowledged to (Name Omitted) local emergency department. care was documented as transferred to emergency department at 06:21:42 (6:21 AM).Review of ED to Hosp-admission (Discharge) in (Name Omitted) critical care Discharge Note for Resident #1 revealed .XXX[AGE] year old lady with dementia with psychotic features, major depressive disorder, atrial fibrillation (irregular heart rhythm) on Eliquis (blood thinner medication).was brought in on [DATE] from her health care facility (Name Omitted) where she was found unresponsive. On EMS arrival patient was hypotensive (low blood pressure), tachycardic, (fast heart rate). cool and cyanotic (blue in color indicated poor blood circulation) extremities (arms and legs). Upon arrival to the ER patient continued to be comatose.and was intubated for airway protection. Notably during intubations, provider noted crushed pill remnants in the back of the throat with concern for polypharmacy versus aspiration of medication. infectious workup. urinalysis concerning for UTI.Hospital course complicated by recurrent hemodynamically unstable (the body's circulatory system cannot maintain adequate blood flow often leading to shock) SVT (Supraventricular tachycardia, a fast or erratic heart rhythm) requiring multiple synchronized cardioversions (quick low-energy shocks to a patient's heart to restore a regular rhythm) . furthermore patient's blood pressure continued to plummet despite escalating doses of vasopressor (medications used to raise blood pressures). concerns for cardiogenic shock (a life-threatening condition characterized by the heart's inability to pump enough blood to meet the body's needs leading to severe symptoms and potential organ failure) on top of sepsis (a life-threatening condition caused by the body's extreme response to an infection) .Patient's condition continued to worsen and blood started oozing out of from all IV (intravenous) access points and repeat labs were concerning for DIC (Disseminated intravascular Coagulation is a rare blood clotting disorder that can cause organ damage and uncontrollable bleeding and can occur as a complication of a very serious medical condition such as an infection). ICU (Intensive Care Unit) team had multiple discussions with patient's family and POA about her worsening medical condition, guarded prognosis, and ultimately family decided to proceed with comfort measures in keeping with patient's wishes. Patient was pronounced deceased at 2319 on [DATE].In an interview on [DATE] at 08:00 AM, Director of Nursing (DON) B reported staffing on the night shift was to try for 3 nurses, but they could work with only 2 nurses. DON B reported there were always 3 nurses for the evening medication pass in the building; if there was a nurse call in then the staffing manager would try to cover the shift, otherwise a clinical care coordinator or DON B would cover the open shift. The covering nurse only had to stay until the evening medication pass was complete. DON B stated .I have been in the building after 10 (PM) and there isn't much to do other than a few PRN's (as needed medications) and dressing changes, you don't need 3 nurses.Review of Clinical Time Punches revealed . Clinical Care Coordinator/Registered Nurse (CCC/RN) EE punched in at 4:55 pm and punched out at 8:21 pm.In an interview on [DATE] at 10:30 AM, Licensed Practical Nurse (LPN) M reported she was mandated to stay over to complete the evening medication pass on [DATE] due to a nurse call in. LPN G reported she left as soon as the evening medication pass was complete because she was scheduled to return the next morning. LPN M reported CCC/RN EE did not take the cart from her or (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	complete a medication pass. Review of Clinical Time Punches revealed .LPN M punched out at 7:19 PM.In an interview on [DATE] at 12:08 PM, DON B reported there were two clinical care coordinators that could assigned to cover an open shift on the floor. DON B reported that CCC/RN EE was one of them but did not cover shifts working on the floor.In an interview on [DATE] at 12:42 PM Infection Prevention Manager/Registered Nurse (IPM/RN) L reported CCC EE was in the building on [DATE] to provide educational trainings to employees, she did not work the floor during that shift.CCC/RN EE was not available during the survey.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview, and record review, the facility failed to complete an annual performance review for 2 Certified Nursing Assistants (CNAs) (CNA's F and DD) of 5 CNA's reviewed for annual performance evaluations, resulting in the potential for unidentified CNA performance concerns, a lack of training related to staff performance review outcomes, and the potential for unmet care needs.Findings include:In an email on 1/16/26 at 1:47 PM, Nursing Home Administrator (NHA) A provided information indicating CNA F was hired on 8/24/24 and no performance evaluation had been completed; and CNA DD was hired on 3/9/15 and the last documented performance evaluation was completed on 3/19/24.In an interview on 1/16/26 at 1:50 PM, NHA A reported CNA F and CNA DD did not have completed performance reviews. NHA A reported Director of Nursing (DON) B was responsible for completing performance evaluations, and Human Resource (HR) KK was responsible for maintaining a list of when performance evaluations needed to be completed.In an interview on 1/16/26 at 1:55 PM, DON B reported she was unaware she was responsible for completing performance evaluations for CNA's and she had never completed one since she began working for the company about 5 months ago.In an interview on 1/16/26 at 1:55 PM, Regional Clinical Support (RCS) GG reported performance evaluations should be completed annually on the employee's anniversary date of hire.HR KK was unavailable during the survey.No performance evaluations for CNA F and CNA DD were available for review by the end of survey.Review of The Essentials Guide to Healthcare Performance Reviews, www.hrforhealth.com , 2024, revealed The benefits of healthcare performance reviews go beyond creating a better experience for your team.the most important (benefit) is performance reviews lead to improved performance.greater productivity and better overall experience for your patients.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents were free from significant medication errors in 1 (Resident #1) of 1 resident reviewed for significant medication error resulting in the potential for Resident #1 to experience lethargy (decreased alertness and response), dizziness, and an increased risk for falls.Findings include:Resident #1 Review of an admission Record revealed Resident #1 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: bipolar disorder (a mental health disorder characterized by significant mood swings), dementia (a syndrome characterized by a decline in cognitive function affecting memory, thinking, behavior, and the ability to perform everyday activities) and delusional disorder (serious mental health condition characterized by persistent, false beliefs that are not based in reality, often leading to significant distress and impairment in functioning).Review of Physician Order for Resident #1 revealed Metoprolol Succinate ER (extended release) Oral tablet extended release 24 hour 25 mg (milligram) give 25 mg by mouth one time a day for htn (hypertension- high blood pressure), hold if systolic (top number in a blood pressure reading) is <110 (less than) or pulse < 60 (less than) and notify the MD (doctor).with a start date of 10/7/25 and no noted revisions during Resident #1's stay.Review of Medication Administration Record (MAR) for Resident #1 for the month of October, 2025 revealed .on 10/9/25 BP (blood pressure) documented was 107/64, on 10/12/25 BP documented was 102/56, On 10/15/25 BP documented was 106/53, on 10/24/25 BP documented was 107/63, on 10/26/25 BP documented was 94/76, on 10/19/25 BP documented was 107/58. all dates were documented that the medication was administered to Resident #1.Review of Medication Administration Record (MAR) for Resident #1 for the month of November, 2025 revealed . on 11/2/25 BP documented was 103/61, on 11/3/25 BP documented was 106/64, on 11/6/25 and 11/7/25 BP documented was 100/61, on 11/8/25 BP documented was 108/72, on 11/18/25, BP documented was 105/59, and on 11/27/25 BP documented was 109/27. all dates were documented that the medication was administered to Resident #1.Review of Medication Administration Record (MAR) for Resident #1 for the month of December, 2025 revealed .on 12/3/25 BP documented was 103/68, on 12/6/25 and 12/7/25 BP documented was 104/62, 12/9/25 BP documented was 106/60, on 12/11/25 BP documented was 109/66, on 12/13/25 BP documented was 104/62. all dates were documented that the medication was administered to Resident #1.Review of Resident #1's medical record revealed no noted documentation of any provider being notified of blood pressure reading outside of ordered parameters.In an interview on 1/14/26 at 10:19 AM Licensed Practical Nurse (LPN) G reported if a medication has parameters such as holding for a specific blood pressure or pulse, you check the vital sign and if it's outside of the parameter, you should not give it.In a telephone interview on 1/14/26 at 9:42 AM Physician Assistant (PA) BB reported per the way the metoprolol succinate order for Resident #1 was written it should have been held, not given to the resident on the dates the BP reading had a systolic number less than 110. PA BB reported he only covers the facility occasionally when on call and would not be the provider who would receive any notification if or when the medication was held.In a telephone interview on 1/14/26 at 11:31 AM, Nurse Practitioner (NP) CC reported a physician order should be followed, and she does not recall ever getting notified that Resident #1's metoprolol succinate was held. NP CC reported Resident #1's metoprolol succinate should have been held every time her systolic BP reading was below 110.In an interview on 1/14/26 at 12:33 PM, Director of Nursing (DON) B reported her expectations were that medications were given per the physician order. When queried, regarding Resident #1's MARs for October, November, and December 2025, DON B reported Resident #1's metoprolol succinate should only be given if the provider was contacted when Resident #1's BP was outside of the parameters. DON B reported if (continued on next page)

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	235625	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the provider was not contacted, and the medication was given it was a mediation error.

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F 0940 Level of Harm - Actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that an effective training program for newly hired nurses was provided and monitored for all newly hired nurses in 1 of 1 resident (Resident #1) reviewed for training, resulting in a delay in treatment and emergent hospital transfer for Resident #1. Findings include:Resident #1Review of Interdisciplinary Documentation for Resident #1 dated [DATE] at 03:16 AM (3:16 am) and authored by Registered Nurse (RN) V at 8:19 am on [DATE] revealed .PA (physician assistant) notified of patient's change in condition, including hypotension (83/56 BP Blood pressure).lethargy, cool skin, significant bilateral lower-extremity edema, and blue-to purplish fluid-filled blisters on posterior heels bilaterally. After discussion, PA agreed patient requires hospital evaluation. Hospital notified and report given. Preparation initiated for transfer to hospital. Focus at this time is on facilitating transport and maintain patient safety while awaiting transfer.Review of Interdisciplinary Documentation for Resident #1 dated [DATE] at 08:19 AM (8:19 am) revealed .Patient transferred to hospital for further evaluation per provider recommendation. Report given to receiving hospital staff and transport personnel. Patient departed facility via ambulance in stable condition at time of departure. Facility notified as appropriate. Documentation completed.In a telephone interview on [DATE] at 5:13 PM, Registered Nurse (RN) V reported on [DATE] she had to transfer two residents to an acute care hospital for changes in condition and she had never done it before. RN V reported RN P was assisting her to complete her orientation training check list that night, which included training on transferring a resident to an acute care hospital, which she had not done yet. RN V stated I started at the end of [DATE], and I have not yet completed all my training. RN V reported RN P was assisting her with completing the paperwork for a transfer to the hospital, the steps to take, the check list to be completed, and the packet that had to be filled out. RN V stated I asked (RN P) should we just call 911 (for Resident #1) and RN P told me to finish up the paperwork, she was going to go eat something, and then she would help me again when she was done. RN V stated when she transferred the first resident to the hospital that night I learned that 911 comes really fast and if you don't have the paperwork filled out, they won't wait for you, and then they don't have what they need. RN V reported she recalled that she did not complete the paperwork correctly for the first resident she transferred from the facility this shift.In a telephone interview on [DATE] at 9:54 AM, EMS [NAME] Specialist (EMS/BS) Z reported on [DATE], the (Name Omitted) local emergency room contacted (Name Omitted) local EMS ambulance services, reported the facility was unable to contact 911 due to a telephone issue, and needed a patient transported from the facility that (Name Omitted) local emergency room had received report on, but did not receive the patient.In a telephone interview on [DATE] at 10:08 AM, 911-Service Specialist (SS) AA reported 911 EMS received two calls for the facility on [DATE], one at 3:20 AM the call was for an ambulance at (Name Omitted), and (Name Omitted) ambulance service was dispatched at 3:25 AM, the call was clear at 5:01 AM. When queried, SS AA reported a call being clear meant the patient that was transported was in the care of the hospital and the ambulance was back in service, available for another call. SS AA reported an abandoned call was received at 5:24 AM from the facility. When queried, SS AA reported an abandoned call indicated a call was made but was disconnected for some reason and no conversation occurred. SS AA reported 911 returned the abandoned call and was informed there was no emergency at the location. SS AA reported 911 received a call at 5:29 AM from the local emergency department and a call at 5:30 AM from the ambulance service, advising they had received a call from the local emergency department, indicating that they had received a call from the facility providing report on a patient and had not (continued on next page)

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F 0940 Level of Harm - Actual harm Residents Affected - Few	received the patient yet. Review on Call for Service Detail Report - CFS 2334 dated [DATE] at 5:29:55 AM revealed .5:30:16 AM (Name Omitted) ambulance service also calling in - advising they got a call from the hospital that THEY got a call from (Name Omitted) facility of an unresponsive male over an hour ago. 5:30:26 AM now getting an [NAME] (abandoned) from (Name Omitted) facility.5:33:04 AM Spoke with (Name Omitted) staff (Name Omitted) Facility who confirmed no emergency.5:33:13 AM close call.5:34:17 AM call reactivated. 5:37:46 AM (Name Omitted) ambulance service just called back- 77 y/o year old female hypertensive, unresponsive- (Name Omitted) Facility said they couldn't get thru to 911- in cardiac arrest - (Name Omitted) ambulance service contact at the hospital is (Name Omitted) at (Name Omitted) local emergency department- .5:39:08 AM ambulance dispatched (unit 4010). 5:41:03 AM per (Name Omitted) ambulance service no police or mfr's (medical first responders) needed.7:39:16 AM call cleared, close call.Review of Incident Detail Report dated [DATE] at 5:36:12 AM revealed .XXX[DATE] 05:36:58 AM, 77 yo (year old) female called in by (Name Omitted) ER (emergency room), (Name Omitted) facility staff said they were unable to get ahold of (Name Omitted) 911 due to phone issues.Review on Prehospital Care Report Summary for Resident #1 dated [DATE] revealed . call received 05:36:12 (5:36 am), dispatched at 05:37:05 (5:37 am).Initial patient acuity: Emergent (yellow).Lights and sirens, destination.Dispatch reason: 9 cardiac or respiratory arrest/death.Provider impression. unconscious. Vitals. 5:49:32 (5:49 am) BP 136/108 (normal value - 110/75 to 130/85 with 120/80 being standard normal reading), Pulse 79 (normal value - 60 to 100 beats per minute), Resp (respirations, normal value - 12 to 20 per minute) 24, SpO2 62 (normal value - 90 to 100 with readings below 90 requiring immediate medical attention). 05:57 am BP 161/122, Pulse 95, SpO2 85. 5:59 am, 177/144, Pulse 114, Resp 23, SpO2 89. 6:03 am BP 192/155, Pulse 100, Resp 31, SpO2 78.6:11 am, 197/166, Pulse 67, Resp 25. Narrative History Text: was dispatched to (Name Omitted) facility for a reported full cardiac arrest. Upon arrival, the crew was met at the entrance by facility staff.Two staff members were present in the room. No CPR or ventilations were in progress. when asked for the latest status update, staff stated the patient was breathing now and has a pulse and then exited the room to retrieve paperwork. The patient was found unconscious, breathing spontaneously, with a palpable pulse. The patient was warm to the touch and was receiving oxygen via nasal cannula (a medical device used to deliver oxygen to a patient through their nostrils) at 3 LPM (liters per minute). initial heart rate and pulse oximetry (SpO2- measure oxygen saturation of the blood) were obtained, SpO2 was noted low. oxygen was increased to 6 LPM vial nasal cannula.Once loaded. patient remained minimally responsive. Due to continued hypoxia (low levels of oxygen in the body tissues) and mental status, oxygen delivery was upgraded to a non-rebreather mask at 15 LPM.ETCO monitoring (End Tidal Carbon Dioxide monitoring used to assess a patient's respiratory status and overall health. Measure the concentration of carbon dioxide in exhaled are at the end of a respiration) was applied, revealing tachypnea (rapid respirations) with low CO2 values (inadequate amounts of carbon dioxide being expelled from the body) The patient remained unresponsive to verbal stimuli and responsive only to painful stimuli (sternal rub).radio report was given and acknowledged to (Name Omitted) local emergency department. care was documented as transferred to emergency department at 06:21:42 (6:21 AM).Review of ED to Hosp-admission (Discharge) in (Name Omitted) critical care Discharge Note for Resident #1 revealed .XXX[AGE] year old lady with dementia with psychotic features, major depressive disorder, atrial fibrillation (irregular heart rhythm) on Eliquis (blood thinner medication).was brought in on [DATE] from her health care facility (Name Omitted) where she was found unresponsive. On EMS arrival patient was hypotensive (low blood pressure), tachycardic, (fast heart rate). cool and cyanotic (blue in color indicated poor blood circulation) extremities (arms and legs). Upon arrival to the ER patient continued to (continued on next page)

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F 0940 Level of Harm - Actual harm Residents Affected - Few	be comatose.and was intubated for airway protection. Notably during intubations, provider noted crushed pill remnants in the back of the throat with concern for polypharmacy versus aspiration of medication. infectious workup. urinalysis concerning for UTI.Hospital course complicated by recurrent hemodynamically unstable (the body's circulatory system cannot maintain adequate blood flow often leading to shock) SVT (Supraventricular tachycardia, a fast or erratic heart rhythm) requiring multiple synchronized cardioversions (quick low-energy shocks to a patient's heart to restore a regular rhythm) . furthermore patient's blood pressure continued to plummet despite escalating doses of vasopressor (medications used to raise blood pressures). concerns for cardiogenic shock (a life-threatening condition characterized by the heart's inability to pump enough blood to meet the body's needs leading to severe symptoms and potential organ failure) on top of sepsis (a life-threatening condition caused by the body's extreme response to an infection) .Patient's condition continued to worsen and blood started oozing out of from all IV (intravenous) access points and repeat labs were concerning for DIC (Disseminated intravascular Coagulation is a rare blood clotting disorder that can cause organ damage and uncontrollable bleeding and can occur as a complication of a very serious medical condition such as an infection). ICU (Intensive Care Unit) team had multiple discussions with patient's family and POA about her worsening medical condition, guarded prognosis, and ultimately family decided to proceed with comfort measures in keeping with patient's wishes. Patient was pronounced deceased at 2319 on [DATE].In an interview on [DATE] at 9:31 AM, RN P reported on the night of [DATE], when RN V had more than one resident who was transferred to the hospital, RN V was overwhelmed and RN P reported she tried to help her with the paperwork required to transfer a resident to the hospital. RN P reported she did not think RN V had ever had to transfer someone to the hospital and was not familiar with the process.In an interview on [DATE] at 3:45 PM, DON B and Nursing Home Administrator (NHA) A reported each new nurse was given 5 days of training when they were hired. DON B reported a nurse could have more days of training if they asked for them. DON B reported each nurse was given a checklist to complete addressing training items. DON B reported the check list does not have to be completed for the check list to be returned to DON B.Review of Licensed Nurse - Orientation and Skill Check. revealed .Emergency Procedures.Director of Health Care Services.Hospitalization.Transfer form from electronic record.Emergency access for Rapid Transport.In an interview on [DATE] at 3:50 PM, DON B reported RN V had not turned in her orientation training checklist, and she was not aware what was complete and what wasn't.The orientation checklist for RN V was not provided by the time of exit.

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F 0947 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review the facility failed to ensure Certified Nurse Assistants (CNA's) completed the required 12 hours of in-service training to ensure continued competency in 1 of 5 CNA's reviewed for in-service training, resulting in the potential for a decrease in resident safety.Findings include:In an email on 1/16/26 at 1:47 PM, Nursing Home Administrator (NHA) A provided information indicating CNA F was hired on 8/24/24 and had completed 0 hours of in-service training.Review of a list provided by NHA A for CNA F with the assigned in-service trainings, revealed documentation that CNA F had Not Attempted to complete any assigned in-service trainings.In an interview on 1/16/26 at 1:50 PM, NHA A reported CNA F did not have 12 hours of completed in-service trainings. NHA A reported the in-services were assigned at the beginning of the year and monthly. CNAs were notified when new training has been assigned electronically. NHA A reported Human Resource (HR) KK was responsible for maintaining a list of employees and training completions. HR KK was unavailable during the survey.